JENNY BOWEN STOREY, M.A. MFT
Licensed Marriage and Family Therapist

12401 Wilshire Boulevard, Suite 303
Los Angeles, CA 90025
(310) 213-9888
License # MFC 47036

CLIENT INFORMATION FORM

Name: _____
(Last) (First) (Middle Initial)

Name of parent(s)/guardian(s) (if under 18 years):

_____
(Last) (First) (Middle Initial)

_____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: _____ May I leave a message? □Yes □No
Cell/Other Phone: _____ May I leave a message? □Yes □No
Birth Date: _____ **Age:** _____

Marital Status:
X □Never Married □ Married □ Separated □ Divorced □ Widowed □ Other_____

Please list any children/age:

_____

Emergency Contact Information:

Name: _____

Address: _____

Phone: _____

- **Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?**
  □ No □ Yes, previous therapist/practitioner: _____

- **Are you currently taking any prescription medication?**
  □ No □ Yes Please list: _____

- **Have you ever been prescribed psychiatric medication?**
  □ No □ Yes Please list and provide dates
  _____

- **Are you currently experiencing sadness, grief or depression?**
  □ No □ Yes If yes, for approximately how long? _____

- **Have you ever seriously thought about hurting yourself?**
  □ No □ Yes If yes, are you currently?_____ How long ago?_____

- **How much alcohol do you drink each week?**_____

- **Do you engage in recreational drug use?** If yes, how often?_____
  What kind?_____

- **Are you currently employed?** □ No □ Yes
  If yes, what is your current employment situation:

  _____

What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

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OFFICE POLICIES

CONFIDENTIALITY

By law and professional ethics, your sessions are strictly confidential. Generally, no information will be shared with anyone without your written permission. If you are seeing another therapist or health professional it may be necessary for me to contact that person so that we can coordinate our efforts to best help you.

Regarding couples counseling, I employ a "no secrets" policy. This means that if you are seeing me with your partner and information arises through an individual conversation, that information may be shared in the couples session at my discretion if therapeutically appropriate.

There are some exceptions to confidentiality required by law which include the following:

- If I am ordered by the court to testify or release records.
- If you are a victim or perpetrator of child abuse I am required to report this to the authorities responsible for investigating child abuse.
- If you are a victim or perpetrator of elder or dependent adult abuse, I am required by law to report this to Adult Protective Services or other appropriate authorities.
- If you threaten harm to yourself, someone else, or the property of others, I may be required to call the police and warn the potential victim, or take other reasonable steps to prevent the threatened harm.

FEES

Your fee will be determined prior to the first therapy session and will be based on a 50-minute therapy hour. You are expected to pay for therapy at the beginning or end of each session unless other arrangements have been made. Fees may be changed during the course of therapy with reasonable notice. If you have financial concerns, please discuss them with me so that they can be mutually resolved.

INSURANCE

I accept Cigna insurance but do not bill other insurance companies directly. If you wish to use another insurance, please consult with your insurance provider prior to your session. I can provide you with a statement at the end of the month marked "PAID" which you may submit to your insurance company for reimbursement directly to you. Please note that typically, insurance companies require additional information from you and you may not have the extent of confidentiality you would otherwise expect.

CANCELLATIONS

You are expected to pay for each session and will be charged for missed sessions unless you provide 24 hours notice of cancellation.

THERAPIST AVAILABILITY

I will make every effort to return calls within 24 hours but cannot guarantee the calls will be returned immediately. I am not able to provide 24-hour crisis services; in the event that you are feeling unsafe or require immediate medical or psychiatric assistance, please call 911 or go to the nearest emergency room.

I/we have read, understand and agree to the information and policies described in this form.

_____	_____	_____
Client/Legal Guardian Name (print)	Signature	Date
_____	_____	_____
Client/Legal Guardian Name (print)	Signature	Date